# Proposed
# Preferred Drug List

**with**

# Clinical Criteria

## Proposal for TennCare

**4.26.05**
**Rev 4.18.05**

# ACE Inhibitors, Angiotensin II Receptor Antagonists, Beta-Blockers, Calcium Channel Blockers

**LENGTH OF AUTHORIZATIONS:** ONE YEAR-IF MEDICALLY JUSTIFIED. OTHERWISE A GRIER 1 MONTH APPROVAL

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?
   *Acceptable reasons include:*
   - **Allergy** to medications not requiring prior approval
   - **Contraindication** to or drug-to-drug interaction with medications not requiring prior approval
   - **History** of unacceptable/toxic side effects to medications not requiring prior approval

2. The requested medication may be approved if both of the following are true:
   - If there has been a therapeutic **failure to no less than a one-month trial** of **at least two medications within the same class** not requiring prior approval with a documented prescription record showing compliance.
   - The requested medications corresponding generic (if a generic is available) has been attempted and failed or is contraindicated

3. The requested medication may be approved if the following is true:
   - An indication which is unique to a non-preferred agent and is supported by peer-reviewed literature or an FDA approved indication exists.

# ACE INHIBITORS
## (A4D)

| PREFERRED | PA REQUIRED |
|---|---|
| BENAZEPRIL (compares to Lotensin®)<br>CAPTOPRIL (compares to Capoten®)<br>ENALAPRIL (compares to Vasotec®)<br>LISINOPRIL (compares to Prinivil® and Zestril®) | ACCUPRIL® (quinapril)<br>ACEON® (perindopril)<br>ALTACE® (ramipril) – see existing criteria below<br>CAPOTEN® (generic available)<br>FOSINOPRIL (generic of Monopril®)<br>LOTENSIN® (generic available)<br>MAVIK® (trandolapril)<br>MOEXIPRIL (generic of Univasc®)<br>MONOPRIL® (fosinopril)<br>QUINAPRIL (generic of Accupril®) |

# ACE INHIBITOR/DIURETIC COMBINATIONS (A4D)

| PREFERRED | PA REQUIRED |
|---|---|
| BENAZEPRIL/ HCTZ (compares to Lotensin HCT®)<br>CAPTOPRIL/ HCTZ (compares to Capozide®)<br>ENALAPRIL/ HCTZ (compares to Vaseretic®)<br>LISINOPRIL/HCTZ (compares to Prinizide® and Zestoretic®) | ACCURETIC® (generic available)<br>CAPOZIDE® (generic available)<br>FOSINOPRIL HCT (generic of Monopril HCT®)<br>LOTENSIN HCT® (generic available)<br>MONOPRIL HCT® (fosinopril/hctz)<br>PRINIZIDE® (generic available)<br>QUINARETIC® (generic of Accuretic®)<br>UNIRETIC® (moexipril/hctz)<br>VASERETIC® (generic available)<br>ZESTORETIC® (generic available) |

**ALTACE®**

**Altace® will be authorized only if the recipient has met criteria for the Hope/MicroHope Trial. If any of the following factors are present then a prior authorization may be given:**

**Inclusions:**

- **History of any one of the following:**
  - **Coronary Artery Disease (CAD)**
  - **History of Stroke**
  - **Peripheral vascular disease**
  - **Diabetes**
  - **Chronic renal disease (CrCl defined as < 40ml/min)**

# ACE INHIBITOR/CALCIUM CHANNEL BLOCKER COMBINATIONS (A4K)

| PREFERRED | PA REQUIRED |
|---|---|
| LOTREL® (amlodipine/benazepril) | LEXXEL® (felodipine/enalapril)<br>TARKA® (trandolapril/verapamil) |

## ANGIOTENSIN II RECEPTOR BLOCKERS (ARBS)
## (A4F)

| PREFERRED* | PA REQUIRED |
|---|---|
| COZAAR®* (losartan)<br>DIOVAN®* (valsartan) | ATACAND® (candesartan)<br>AVAPRO® (irbesartan)<br>BENICAR® (olmesartan)<br>MICARDIS® (telmisartan)<br>TEVETEN® (eprosartan) |

## ARB/DIURETIC COMBINATIONS
## (A4F)

| PREFERRED* | PA REQUIRED |
|---|---|
| HYZAAR®* (losartan/HCTZ)<br>DIOVAN HCT®* (valsartan/HCTZ) | ATACAND HCT® (candesartan/HCTZ)<br>AVALIDE® (irbesartan/HCTZ)<br>BENICAR HCT® (olmesartan/HCTZ)<br>MICARDIS HCT® (telmisartan/HCTZ)<br>TEVETEN HCT® (eprosartan/HCTZ) |

| ***ARBs and ARB diuretics Class Criteria** |
|---|
| Angiotensin II Receptors Blockers used for hypertension will be reserved for those patients who have a contraindication to an ACE-inhibitor (history of ACE-induced angioedema, hypersensitivity to ACE inhibitors, pregnancy) or are unable to tolerate an ACE-inhibitor due to cough.<br><br>Angiotensin II Receptors Blockers will be approved for patients with diabetic nephropathy, heart failure, or left ventricular hypertrophy. |

# BETA-BLOCKERS
# (J7C)

| PREFERRED | PA REQUIRED |
|---|---|
| ACEBUTOLOL (compares to Sectral®)<br>ATENOLOL (compares to Tenormin®)<br>ATENOLOL/CHLORTHALIDONE (compares to Tenoretic®( (A4Y)<br>BETAXOLOL (compares to Kerlone®)<br>BISOPROLOL FUMARATE (compares to Zebeta®)<br>BISOPROLOL/HCT (compares to Ziac®) (A4Y)<br>METOPROLOL HCT (compares to Lopressor HCT®( (A4Y)<br>METOPROLOL TARTRATE (compares to Lopressor®)<br>NADOLOL (compares to Corgard®)<br>PINDOLOL (compares to Visken®)<br>PROPRANOLOL (compares to Inderal®)<br>PROPRANOLOL HCT (compares to Inderide®( (A4Y)<br>SOTALOL AF (compares to Betapace AF®)<br>SOTALOL HCL (compares to Betapace®)<br>TIMOLOL MALEATE (compares to Blocadren®) | BETAPACE® (generic available)<br>BETAPACE AF® (generic available)<br>BLOCADREN® (generic available)<br>CARTROL®<br>CORGARD® (generic available)<br>CORZIDE® (A4Y)<br>INDERAL® (generic available)<br>INDERAL LA®-see criteria below<br>INDERIDE® (A4Y) (generic available)<br>INNOPRAN XL®<br>KERLONE® (generic available)<br>LEVATOL®<br>LOPRESSOR® (generic available)<br>LOPRESSOR HCT® (A4Y) (generic available)<br>SECTRAL® (generic available)<br>SORINE®<br>TENORETIC® (A4Y) (generic available)<br>TENORMIN® (generic available)<br>TIMOLIDE® (A4Y)<br>TOPROL XL®-see criteria below<br>VISKEN® (generic available)<br>ZEBETA® (generic available)<br>ZIAC® (A4Y) |

| **INDERAL LA® criteria** |
|---|
| • Propanolol LA (generic of Inderal LA®) is currently not being manufactured. |
| • If use is for either Essential Tremor or Migraines than the Brand Name Long-Acting formulation will be authorized. The required trial a Non PA request agent will not be required. (*Discussion on propranolol IR use in migraines/essential tremor)* |
| • If DX is HTN alone then other agents will be offered or a failure on one other Beta-Blocker will be required prior to authorization |

| **TOPROL XL®: Criteria** |
|---|
| • The recipient must have a diagnosis of Congestive Heart Failure (CHF) or cardiomyopathy |
| • A quantity limit of 45 tablets |

# ALPHA/BETA-BLOCKERS
(J7A)

| PREFERRED* | PA REQUIRED |
|---|---|
| LABETALOL (compares to Trandate®) | COREG®-see criteria listed below<br>TRANDATE® (generic available) |

| COREG® criteria |
|---|
| • Verify that the patient is not on another concurrent Beta-Blocker |
| • Verify that the patient is not on another concurrent Alpha $_1$Adrenergic blocker (ie Hytrin,® Prazosin,® Cardura® etc) |
| • Verify the patient has **one** of the following:<br>1. CHF<br>2. Patient has survived the acute phase of an MI and has an LVEF of 40% or less (with or without symptomatic heart failure) |
| • If all of the above are true than authorize the medication |
| **Note:** If the patient is on a concurrent Beta-Blocker or Alpha $_1$Adrenergic blocker (ie Hytrin®, Prazosin®, Cardura® etc) plus Coreg® than the duplication will be questioned. |

# CALCIUM CHANNEL BLOCKERS
# (A9A)

## Dihydropyridine Calcium Channel Blockers (DHPCCB)

| PREFERRED | PA REQUIRED |
|---|---|
| FELODIPINE ER (compares to Plendil®)<br>NICARDIPINE HCL (compares to Cardene®)<br>NIFEDIPINE IR (compares to Adalat® and Procardia®)<br>NIFEDIPINE ER/SA/XL (multiple long acting nifedipine generics that compare to Adalat CC® and Procardia XL®)<br>NORVASC® (amlodipine) | ADALAT® (generic available)<br>ADALAT CC® (generic available)<br>CARDENE® (generic available)<br>CARDENE SR®<br>DYNACIRC® (isradipine)<br>DYNACIRC CR® (isradipine long acting)<br>PLENDIL® (generic available)<br>PROCARDIA® (generic available)<br>PROCARDIA XL® (generic available)<br>SULAR® (nisoldipine) |

## NON Dihydropyridine Calcium Channel Blockers (NDHPCCB)

| PREFERRED | PA REQUIRED |
|---|---|
| DILTIAZEM ER/SR/XR (compares to Cardizem SR®, Dilacor XR®, Cardizem CD®,and Tiazac®)<br>DILTIAZEM IR (compares to Cardizem®)<br>VERAPAMIL HCL (compares to Calan®)<br>VERAPAMIL EXTENDED RELEASE (compares to Calan SR® and Isoptin SR®) | CALAN® (generic available)<br>CALAN SR® (generic available)<br>CARDIZEM® (generic available)<br>CARDIZEM CD® (generic available)<br>CARDIZEM LA®<br>COVERA HS®<br>DILACOR XR® (generic available)<br>ISOPTIN SR® (generic available)<br>TIAZAC® (generic available)<br>VERELAN® (generic available)<br>VERELAN PM® (generic available) |

# Beta-Adrenergic Agents

**LENGTH OF AUTHORIZATIONS**: ONE YEAR-IF MEDICALLY JUSTIFIED. OTHERWISE A GRIER 1 MONTH APPROVAL

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?
   *Acceptable reasons include:*
   - **Allergy** to medications not requiring prior approval
   - **Contraindication** to or drug-to-drug interaction with medications not requiring prior approval
   - **History** of unacceptable/toxic side effects to medications not requiring prior approval
   - Document clinically compelling information

2. The requested medication may be approved if both of the following are true:
   - If there has been a therapeutic **failure to no less than a one-month trial** of **the preferred medication within the same class** not requiring prior approval with a documented prescription record showing compliance.
   - The requested medications corresponding generic (if a generic is available) has been attempted and failed or is contraindicated
3. The requested medication may be approved if the following is true:
   - An indication which is unique to a non-preferred agent and is supported by peer reviewed literature or an FDA approved indication exists.

## BETA-ADRENERGIC AGENTS
### Short Acting Meter Dose Inhalers or Inhalation Devices
### (J5D)

| PREFERRED | PA REQUIRED |
|---|---|
| ALBUTEROL MDI (compares to Proventil®) | ALUTEROL HFA (not A/B equiv to Proventil/Ventolin HFA®)-see criteria below<br>ALUPENT MDI ® (metaproterenol)<br>MAXAIR AUTOINHALER® (pirbuterol)-see criteria below<br>PROVENTIL® (albuterol)<br>PROVENTIL HFA ® (albuterol)<br>VENTOLIN HFA ® (albuterol)<br>XOPENEX® (levalbuterol) |

| MAXAIR AUTOINHALER® |
|---|
| • If there is an inability to use other press and breath Meter Dose Inhalers due to poor technique/skill due to age or physical factors (ie arthritis), then MAXAIR® AUTOINHALER will be approved |

| ALBUTEROL HFA |
|---|
| • If patient has had a reaction to a CFC Inhaler, but has appropriate technique, then Abuterol HFA will be authorized |

## BETA-ADRENERGIC AGENTS: LONG ACTING
### Meter Dose Inhalers

| PREFERRED* | PA REQUIRED |
|---|---|
| SEREVENT DISKUS®<br>FORADIL ® | |

| *SEREVENT DISKUS®, AND FORADIL® CRITERIA |
|---|
| • In the treatment of asthma or the treatment of other reversible airway disease(s) where optimal doses of inhaled steroids are being used and breakthrough symptoms require frequent use of inhaled short-acting bronchodilators.<br>• In the treatment of COPD as a second-line agent in patients who remain symptomatic despite treatment with ipratropium and short-acting beta-agonists. |

## BETA-ADRENERGIC AGENTS: SHORT-ACTING
### Nebulizers

| PREFERRED | PA REQUIRED |
|---|---|
| ALBUTEROL<br>**Solution for inhalation** : 0.5% (5 mg /mL)<br>**Solution for inhalation** : 0.083% (2.5 mg per 3 mL)<br>**Solution for inhalation** : 0.042% (1.25 mg per 3 mL) (Preservative Free)<br>METAPROTERENOL | ACCUNEB® (0.021% (0.63 mg per 3 mL) and 0.042% (1.25 mg per 3 mL)<br>ALUPENT Inhalation ®<br>XOPENEX ® |

| **XOPENEX® (Levalbuterol nebulization) Considerations** |
|---|
| • Prior authorization not required for beneficiaries ages 10 and under and ages 60 and older. |
| • Authorized for patients age 11 through 59 for those still experiencing side-effects with ½ strength dosage trial of albuterol |
| • Authorized for patients whose cardiovascular status is considered to be in severe deteriorating condition (in this situation a trial of one other agent is not required) |

BETA-ADRENERGICS
## MISCELLANEOUS COMBINATION PRODUCTS

| PREFERRED | PA REQUIRED |
|---|---|
| | ADVAIR DISKUS® (J5G) (fluticasone and salmeterol) |

| **ADVAIR DISKUS® :** |
|---|
| • Advair will only be approved once the criteria for Serevent® has been met, and the recipient requires the addition of an inhaled corticosteroid |

# COPD Anticholinergics

**LENGTH OF AUTHORIZATIONS**: ONE YEAR-IF MEDICALLY JUSTIFIED. OTHERWISE A GRIER 1 MONTH APPROVAL

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?
   *Acceptable reasons include:*
   - **Allergy** to medications not requiring prior approval
   - **Contraindication** to or drug-to-drug interaction with medications not requiring prior approval
   - **History** of unacceptable/toxic side effects to medications not requiring prior approval
   - Recipient's condition is **clinically unstable**-the recipient has had an ER visit or at least two hospitalizations for COPD/asthma in the past 30 days-changing to a medication not requiring prior approval might cause deterioration of the recipient's condition

2. The requested medication may be approved if both of the following are true:
   - If there has been a therapeutic **failure to no less than a one-month trial** of **at least one medication within the same class** not requiring prior approval with a documented prescription record showing compliance.
   - The requested medications corresponding generic (if a generic is available) has been attempted and failed or is contraindicated

3. The requested medication may be approved if the following is true:
   - An indication which is unique to a non-preferred agent and is supported by peer-reviewed literature or an FDA approved indication exists.

# COPD Anticholinergics

## MISCELLANEOUS COMBINATION PRODUCTS

| PREFERRED | PA REQUIRED |
|---|---|
| ATROVENT AEROSOL® (A1D) (ipratropium) | COMBIVENT MDI®[1] (J5D) (albuterol/ipratropium)-see criteria below<br>DUONEBS® [1] (J5D) (albuterol/ipratropium)<br>SPIRIVA® (A1D) (tiotropium)-see criteria below |

1 The individual components of both Combivent® and Duonebs® are available without prior authorization (Ipratropium nebs and MDI (generic for Atrovent®) available and Albuterol nebs and MDI (generic for Ventolin®, Proventil®)

| **COMBIVENT® : CRITERIA** |
|---|
| • Diagnosis of COPD will automatically authorize Combivent® (no trial required) |

| **SPIRIVA® : CRITERIA** |
|---|
| Patients with Chronic Obstructive Pulmonary Disease (COPD) and who are clinically stable and doing well on ipratropium, Combivent®, and/or a long-acting beta agonist (LABA) should not be switched to tiotropium (Spiriva®). Rather, tiotropium (Spiriva®) should be utilized in moderate to severe COPD patients who have persistent symptoms that interfere with their tasks of daily living and/or have exacerbations on therapies mentioned above. |

| **SPIRIVA® : The following three criteria must be met:** |
|---|
| • A diagnosis of COPD is required |
| • Trial of albuterol nebulized Combivent® or ipratropium ≥ 2 puffs QID (+ albuterol, as needed and tolerated) for at least 3 months |
| • ≥ 2 COPD exacerbations requiring urgent visits to the clinic/emergency room or ≥ 1 exacerbation requiring hospitalization in the last year. COPD exacerbation defined as: a sustained worsening of the patient's condition, from the stable state and beyond normal day-to-day variations, necessitating a change in regular medication in a patient with underlying COPD (Chest 2000; 117:398S-401S). |
| **Note:** Patients on Long term oral steroids are eligible for tiotropium (Spiriva®), provided they have met the first two criteria. |

# Inhaled Corticosteroids

**LENGTH OF AUTHORIZATIONS**: ONE YEAR-IF MEDICALLY JUSTIFIED. OTHERWISE A GRIER 1 MONTH APPROVAL

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?
   *Acceptable reasons include:*
   - **Allergy** to medications not requiring prior approval
   - **Contraindication** to or drug-to-drug interaction with medications not requiring prior approval
   - **History** of unacceptable/toxic side effects to medications not requiring prior approval
   - Recipient's condition is **clinically unstable**-the recipient has had an ER visit or at least two hospitalizations for COPD/asthma in the past 30 days-changing to a medication not requiring prior approval might cause deterioration of the recipient's condition
   - Document clinically compelling information

2. The requested medication may be approved if the following are true:
   - If there has been a therapeutic **failure to no less than a one-month trial** of at least **two medications within the same class** not requiring prior approval
   - Verify via the recipient's medication history to assure medication compliance
   - The requested medications corresponding generic (if a generic is available) has been attempted and failed or is contraindicated

3. The requested medication may be approved if the following is true:
   - An indication which is unique to a non-preferred agent and is supported by peer-reviewed literature or an FDA approved indication exists.

## INHALED CORTICOSTEROIDS (P5A)

| PREFERRED | PA REQUIRED |
|---|---|
| AZMACORT® (triamcinolone)<br>FLOVENT® (fluticasone)<br>FLOVENT HFA® (fluticasone)<br>QVAR® (beclomethasone) | AEROBID® (flunisolide)<br>AEROBID-M® (flunisolide)<br>PULMICORT TURBUHALER® (budesonide)<br>PULMICORT RESPULES® (budesonide)-see criteria below |

| **PULMICORT RESPULES® :** |
|---|
| • Prior authorization not required for beneficiaries ages 6 and under |

# Leukotriene Modifiers

## LEUKOTRIENE MODIFIERS
**(Z4B)**

| PREFERRED* | PA REQUIRED |
|---|---|
| SINGULAIR® (montelukast) | ACCOLATE® (zafirlukast) |

| *SINGULAIR® : |
|---|
| • Singulair® is unrestricted for those 20 years and younger.<br>• For those over 20 years old: Singulair® is unrestricted in the treatment of asthma.<br>• For treatment of Seasonal Allergic Rhinitis, the patient must have a failed trial of a non-sedating antihistamine and a nasal steroid prior to trying Singulair®. |

# Non Sedating Antihistamines

**LENGTH OF AUTHORIZATIONS**: ONE YEAR-IF MEDICALLY JUSTIFIED. OTHERWISE A GRIER 1 MONTH APPROVAL

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?
   *Acceptable reasons include:*
   - **Allergy** to medications not requiring prior approval
   - **Contraindication** to or drug-to-drug interaction with medications not requiring prior approval
   - **History** of unacceptable/toxic side effects to medications not requiring prior approval
   - Document clinically compelling information

2. The requested medication may be approved if the following are true:
   - If there has been a therapeutic **failure to no less than a one-month trial** of at least **two medications within the same class** not requiring prior approval
   - Verify via the recipient's medication history to assure medication compliance
   - The requested medications corresponding generic (if a generic is available) has been attempted and failed or is contraindicated

4. The requested medication may be approved if the following is true:
   - An indication which is unique to a non-preferred agent and is supported by peer-reviewed literature or an FDA approved indication exists.

## Non-Sedating Antihistamines (Z2O/Z2Q)

| PREFERRED | PA REQUIRED |
|---|---|
| LORATADINE tabs/syrup<br>LORATADINE/PSEUDOEPHEDRINE | ALLEGRA® (fexofenadine)<br>ALLEGRA D® (fexofenadine/pseudoephedrine)<br>CLARITIN® tabs/syrup (generic available)<br>CLARITIN D® (generic available)<br>CLARINEX® tabs/syrup(Desloratadine)<br>CLARINEX-D® (Desloratadine/pseudoephedrine)<br>ZYRTEC® tabs/syrup (certirizine)<br>ZYRTEC D® (certirizine/pseudoephredrine) |

| PA Required non-sedating antihistamines |
|---|
| • Prior authorization not required for beneficiaries ages of 10 and under. Note-the combination products are not indicated for pediatrics < 12 years old. |

# Gastrointestinals: PPIs

## GASTROINTESTINALS: PPIS

**(D4K)**

| NO PA REQUIRED "PREFERRED" | PA REQUIRED |
|---|---|
| NEXIUM® *(*esomeprazole)<br>PREVACID® (lansoprazole)<br>PRILOSEC OTC® (omeprazole) | ACIPHEX® *(*rabeprazole)<br>OMEPRAZOLE (compares to Prilosec®)<br>PREVACID GRANULES® (lansoprazole)<br>PREVACID NAPRAPAC®<br>(lansoprazole/naproxen)<br>PRILOSEC® (omeprazole)<br>PROTONIX® *(*pantoprazole*)*<br>ZEGERID® (omeprazole) |

**PPIs® :**

- **A 4 week therapy trial with an H2RA must have been tried and failed in order to prescribe a PPI unless one of the following diagnosis are present:**
- **Erosive Esophagitis**, grade 2 or greater- Recipient must have tried and failed a 2 week trial of an acute dosage of an H2 Blocker. Diagnosed by a recent endoscopy within the last 2 years. May approve x 8 weeks
- **Barrett's Esophagus, Schatzki's ring-** diagnosed by a recent endoscopy within the last 2 years
- **Pathological Hypersecretory condition (i.e. Zollinger-Ellison syndrome, Multiple Endocrine Adenoma, Systemic Matocytosis**)-diagnosed by a serum gastrin (while the recipient was not on a PPI for 1-2 weeks prior) and a serum secretin stimulation test. May approve for 6 months.
- **GERD grade III-IV, continuing, symptomatic OR GERD, atypical with symptoms of chronic laryngitis, hoarseness, or cough due to reflux-** Recipient must have tried and failed a 2 week trial of an acute dosage of an H2 Blocker. Diagnosed by a endoscopy or esophargram within the last 2 years OR diagnosed by a Upper GI series or Barium swallow within the past 1 year. May approve x 1 year.
- **H. Pylori Positive**-may approve x 1 month at BID dosing
- **NSAID Gastropathy**- diagnosed by a recent endoscopy within the last 2 years
- **GI bleed-**approve x 2 months at QD dosing
- **Hyperacidity in Cystic Fibrosis recipients-**Must have had a recent failure on a acute dose of an H2 blocker
- **Gastric or Duodenal Ulcer or PUD**-Recipient must have tried and failed a 2 week trial of an acute dosage of an H2 Blocker. Diagnosed by a Upper GI procedure within the last month-may approve x 1 month
- **Gastritis, Hiatal Hernia, esophageal stricture, uticaria,** - An H2 Blocker is warranted
- **Indigestion or heartburn**- H2 blocker/PPI therapy is not warranted
- **Gastroparesis-** recent testing must have been performed, along with failure on a prokinetic agent and failure on more than one anti-emetic

- **Twice daily Dosing Criteria**: may approve for a max of 12 weeks therapy.
- Treatment of complicated GERD (i.e. ulcer bleeding, esophageal ulcer, strictures and extraesophageal manifestations of GERD). Re-evaluate at 8 weeks to determine if dose may be decreased to daily dose
- Documented Barrett's metaplasia if inadequate suppression on daily dose
- Persistent symptoms of GERD despite an adequate trial of the addition of bedtime H2-receptor antagonist or prokinetic agent for motility disorder
- Active bleeding in documented duodenal or gastric ulcers
- Hypersecretory conditions such as Zollinger-Ellison Syndrome
- As part of an H. pylori treatment regimen

# Hypoglycemics

**LENGTH OF AUTHORIZATIONS**: ONE YEAR-IF MEDICALLY JUSTIFIED. OTHERWISE A GRIER 1 MONTH APPROVAL

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   - **Contraindication** to or drug-to-drug interaction with medications not requiring prior approval
   - **History** of unacceptable/toxic side effects to medications not requiring prior approval
   - Recipient's condition is **clinically unstable**-changing to a medication not requiring prior approval might cause deterioration of the recipient's condition

2. The requested medication may be approved if both of the following are true:
   - If there has been a therapeutic **failure to no less than a one-month trial** of at least one medication within the same class not requiring prior approval
   - The requested medications corresponding generic (if a generic is available) has been attempted and failed or is contraindicated

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# Hypoglycemics *page 2*

## Thiazolidinediones
(C4N)

| PREFERRED* | PA REQUIRED |
|---|---|
| ACTOS® (pioglitazone) | AVANDIA® (rosiglitazone)<br>AVANDAMET®* |

* Avandamet requires failure of Actos® and concurrent Metformin.

| *Thiazolidinediones |
|---|
| • Should not be used as monotherapy since there is no advantage in reducing HbA1c over sulfonylureas or metformin. |
| • Combination therapy with:<br>  • Sulfonylureas-Inadequate glycemic control with sulfonylureas monotherapy AND an inadequate response to combing a sulfonylurea with metformin.<br>  • Metformin-Inadequate glycemic control with metformin monotherapy AND an inadequate response or have a contraindication to combining metformin with a sulfonylurea or a meglitinide.<br>  • Insulin-When insulin doses are > 50 units/day AND HbA1c > 8% AND had an inadequate response with combination insulin and metformin or have a contraindication to metformin. |

## Biguanides
(C4L)

| PREFERRED | PA REQUIRED |
|---|---|
| METFORMIN HCL (compares to Glucophage®)<br>METFORMIN HCL ER (compares to Glucophage XR®) 500mg, 750mg | FORTAMET® (metformin extended release) 500mg, 750mg, 1000mg<br>GLUCOPHAGE® (metformin) – generic available<br>GLUCOPHAGE XR® (metformin extended release) 500mg, 750mg – generic available<br>RIOMET® (metformin liquid 500mg/5ml) |

# Hypoglycemics *page 3*

## Sulfonylureas and Combination Products
(C4K)

| PREFERRED | PA REQUIRED |
|---|---|
| GLIPIZIDE (compares to Glucotrol®)<br>GLIPIZIDE ER/XL (compares to Glucotrol XL®)<br>GLYBURIDE(compares to Diabeta®, Micronase®)<br>GLYBURIDE/METFORMIN (compares to Glucovance®)<br>GLYBURIDE MICRONIZED (compares to Glynase®) | AMARYL® (glimepiride)<br>DIABETA® (generic available)<br>GLUCOTROL® (generic available)<br>GLUCOTROL XL®(generic available)<br>GLUCOVANCE® (generic available)<br>GLYNASE® (generic available)<br>METAGLIP® (glipizide/metformin) |

| **Amaryl® :** |
|---|
| • If the request is for Amaryl® in combination with insulin, and the preferred drugs cannot be used, then authorize Amaryl® as it is the only sulonylurea FDA indicated for use with insulin. |

## Alpha-Glucosidase Inhibitors
(C4M)

| PREFERRED | PA REQUIRED |
|---|---|
| GLYSET® (miglitol)<br>PRECOSE® (acarbose) | |

## Meglitinides
(C4K)

| PREFERRED | PA REQUIRED |
|---|---|
| STARLIX® (nateglinide) | PRANDIN® (repaglinide) |

# Hypoglycemics, *page 4*

## Insulins

(C4G)

**Bolus Insulins of Human rDNA origin**

| PREFERRED | PA REQUIRED |
|---|---|
| NOVOLIN R® | HUMULIN R® |

**Basal Insulins of Human rDNA origin**

| PREFERRED | PA REQUIRED |
|---|---|
| NOVOLIN N®<br>NOVOLIN L® | HUMULIN N®<br>HUMULIN L®<br>HUMULIN U® |

**Premixed Combination Insulins of Human rDNA origin**

| PREFERRED | PA REQUIRED |
|---|---|
| NOVOLIN 70/30® | HUMULIN 70/30®<br>HUMULIN 50/50® |

**Bolus Insulins : Analogs**

| PREFERRED | PA REQUIRED |
|---|---|
| NOVOLOG® (insulin aspart) | HUMALOG® (insulin lispro) |

**Premixed Combinations (biphasic absorption): analogs**

| PREFERRED | PA REQUIRED |
|---|---|
| NOVOLOG 70/30 | HUMALOG 75/25 |

**Basal Insulins : Analogs/Miscellaneous**

| PREFERRED | PA REQUIRED |
|---|---|
| LANTUS® (insulin glargine) | Symlin* |

* Symlin-requires a failure to achieve adequate glycemic control despite optimal insulin therapy. Document appropriate insulin history.

**Lantus® :**

- Reserved for recipients unable to achieve glycemic control due to recurrent episodes of symptomatic hypoglycemia, especially nocturnal hypoglycemia, despite multiple attempts with various insulin dosing regimens OR
- Recipients receiving highly intensive insulin therapy (such as four times daily administration) including those who would otherwise be candidates for insulin pump therapy AND
- The prescriber must document improvement in either glucose control or hypoglycemia during the first 6 months of treatment. If no improvement is noted, Lantus® should be discontinued.
- *This recommendation is based on the pharmacokinetic/pharmacodynamic profile of Lantus® which suggest a more steady insulin level and which may assist recipients who are trying to maintain very strict and tight control of their blood glucose level while minimizing symptomatic hypoglycemia.*